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ABSTRACT

This simulation employs a case history of an actual crisis intervention in a municipal agency to describe the general principles of change within a social system, to explain the role of the consultants in the change process, and to illustrate a rationale for change procedures. Specifically, the intervention strategy employed to solve internal problems of the health department of the city of Cincinnati is detailed. The case analysis is organized around the major decision points confronting the change agents in order to allow readers to compare their choice of an action strategy with that of the consultants. The text is divided into the following sections: "Entry," "Design of Entry," "Diagnosis/Data Collection," "Data Analysis/Action Steps," and "Review." (KS)

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Faculty Resource Center

CONSULTATION SKILLS DEVELOPMENT: A PARTICIPATIVE CASE ANALYSIS

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A Participative Case Analysis of Crisis Intervention in a Municipal Agency

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INTRODUCTION

When individuals perform as organizational consultants, change agents, or leaders they are in the role of "actor" in relationship to some set of environmental, social, or organizational circumstances. One is a participant attempting to bring about certain ends or facilitate their occurrence. Participative or action roles differ from the traditional observation roles taken on by social scientists in that the participant becomes part of the "action" and must factor in his or her own concepts, values, goals, feelings and actions. If we as individuals are to become skillful in the role of "actor" it is necessary to discover as much as possible about the style, nature, and impact of our participation. In the parlance of cultural anthropology and the applied behavioral sciences one must become a skillful participant-observer. In the role of the anthropologist the typical goal is to observe through participation, usually without any goal to change the social system under study. On the other hand, applied behavioral scientists typically participate for purposes of changing a social system. Thus it is necessary for them to be observant about the behavior of themselves and others to gain insights which will enable them to be more effective in reaching their change goals.

This simulation employs a case history of an actual crisis intervention in a municipal agency.[1] The authors describe the social system being changed, their role in the change process, and the rationale for their behavior. Rather than read the paper from the viewpoint of an observer or social analyst, the case is designed so that individuals and groups can participate as actors in the design intervention as the case

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1 Goodstein, L.D. and Boyer, R.K., "Crisis Intervention in a Municipal Agency: A Conceptual Case History", Journal of Applied Behavioral Science, Washington, D.C., Volume 8, Number 3, 1972.

unfolds. Then they compare their interventions with those utilized by the actual consultants.

The case analysis is organized around the major choice points confronting the change agents (consultants, intervenors). It is divided into several sections. Individuals and groups will first read a section which includes the information then available to the change agents. Next, small groups will address the choice points confronting the change agents and develop an action position on what to do next in the consultation. The group(s) will also develop the rationale for their choice of an action strategy. Following discussion of the various action strategies developed by subgroups the next section of the case study will be read to see what the consultants actually did. Then it will be possible for the groups to compare their choice of an action strategy with those actually utilized by the change agents.

The cycle of reading a section, discussing choice points, developing an action strategy, comparing action strategies among subgroups, reading what the consultants actually did, and comparing hypothesized action strategies with actual events will be repeated three times.

Throughout their work on this case participants should think about such questions as: how do I participate in organizations, what values and feelings do I have which affect what I will or will not do, what is my conception of the change agent's role, and what theories of organization and change do I employ in looking at organizations?

Each section of the case is preceded by a set of guidelines. Proceed according to these guidelines and avoid the "temptation" to read the last page to see what happened.

— GO TO SECTION I —

SECTION I - ENTRY

Guidelines

1. Read the first six pages of the case study (pp 1-6) 10 min.

Crisis Intervention in a Municipal Agency: A Conceptual Case History[1, 2]

Leonard D. Goodstein and Ronald K. Boyer

University of Cincinnati

In the fall of 1970, the Health Department of the City of Cincinnati was in crisis. There were a multitude of internal problems and the Department's relationships with segments of the community were quite poor. The internal problem had led to a number of meetings of groups of dissident employees and they had made their unhappiness with the administration of the Health Department, particularly its Commissioner, a matter of public record. An Ad Hoc Workers Council had been formed and was intent upon changing the Department and securing the termination of the Commissioner's appointment. There had been a number of resignations from the Health Department during the past months, including a special assistant to the Commissioner and an Assistant Commissioner. The circumstances surrounding both of these resignations, among others, were unclear and there was much misunderstanding and suspiciousness within the Department and in the community about these resignations. A number of citizens and neighborhood groups in the community, especially those that were recipients of Health Department services, had begun to voice serious discontent with the quality of services being received. These groups were insisting upon greater community involvement in the management of the Health Department, an involvement for which there was no vehicle.

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For a period of several weeks there had been a constant series of newspaper articles and television news stories about the Health Department. There would have been few people in Greater Cincinnati who did not know that the Health Department was in some kind of difficulty at the time consultation was requested.

BACKGROUND

The Health Department of Cincinnati, an organization of over 300 employees, is established by municipal charter and in conformance with the laws of the State of Ohio and is generally charged with providing both health care services to the needy and with supervising the public health aspects of the environment. The governing Board of Health consists of five persons, each appointed by the Mayor with the approval of the City Council, for 10 years, overlapping terms. At the time in question the Board consisted of an aging pediatrician who was Board President, an aging suburban housewife (these two members had served a total of over 30 years on the Board), a Negro physician, a dentist, and a businessman. The latter two members were very recent appointments and had each only served for several months.

The Board serves without compensation and typically had met only monthly for a fairly brief meeting in which there was routine approval of routine items. The only major issue which the Board had previously

needed to consider was the replacement of the Commissioner. The recent series of events, however, had changed this pattern. There was an interminable series of meetings, both with dissident employees and with community groups, frequently punctuated with the politics of confrontation, high public visibility and concern over the Board's behavior, and a tremendous drain on their energies. Since all of the individuals on the Board had other commitments, including extensive professional practice and business obligations, service on the Board had become arduous and unrewarding, a state of affairs none of the members of the Board had bargained for in accepting an appointment.

The Board is responsible for selecting the Health Commissioner who is ordinarily a physician trained in public health and epidemiology. The incumbent at the time of the consultation was a nationally well-known public health administrator who had been on the job for approximately two years. His predecessor, also a trained public health administrator, had resigned under pressure after a similar, brief term of office. Prior to that the Department had been run by a local physician for a great many years and most of the employees of the Department had been recruited under his regime.

In addition to the Commissioner there are three Assistant Commissioners, one for health care, one for mental health programs, and the third for environmental protection. The Assistant Commissioner

for health care had resigned recently because she had decided that she did not care for the administrative nature of the job, but there also were unresolved personal issues between her and the Commissioner that entered into the decision. The Assistant Commissioner for mental health programs was employed only on a part-time basis and had little to do with the non-psychiatric programs of the Department. He had played almost no role in the present difficulties. The Assistant Commissioner for environmental protection was also a part-time employee of the Department, but was rather central to the affairs of the Department. He had been in office for 18 years and had seen the comings and goings of the several different Commissioners. A well-known environmentalist, he held academic rank at the University's College of Medicine and was also engaged in an extensive consulting practice. There was also a business manager who was responsible for some aspects of routine administration and budgeting.

The Health Department staff included a variety of professional and non-professional personnel including physicians, public health nurses, public health educators, environmental sanitarians, health inspectors, secretaries, record clerks, and so on. Most of these employees were long-term civil service employees of the City whose behavior and aspirations were those typically encountered in large bureaucracies. In addition to its traditional functions of environmental supervision and providing health services, an extensive

community health program had been developed through the auspices of the Pilot Cities program by the Commissioner and a staff which he had brought in to manage this new and innovative program. There was considerable suspicion and jealousy on the part of old-line employees toward this new program and this seemed to be one of the points at issue in the crisis.

ENTRY

Early in September of 1970, the authors were contacted by a psychiatrist who was a staff member of the Division of Mental Health of the Health Department. He was concerned with the tensions, problems, and discontent within the Health Department. Moreover, he felt a personal commitment to the Commissioner whom he both liked and respected. He was concerned about supporting the Commissioner and also enhancing the Commissioner's effectiveness in filling his leadership role within the Health Department. His notion was that a series of workshops on intra-organization communications and leadership would serve to reduce organizational tensions, clarify organizational goals, and consolidate individual and organizational commitments to the delivery of high-quality health care to the community. Following some preliminary discussions with this psychiatrist a meeting was arranged including the authors, the Health Commissioner, and the President of the Board of Health. The psychiatrist had already convinced both the Commissioner and the President of the Board of the

potential utility of workshops with the Health Department. The purpose of the meeting, in their minds, was to negotiate a contract leading to the conduct of the workshops. It was agreed by the principals at this meeting to invite the authors to a special meeting of the Health Board to draw up a contract for such a series of workshops. Some preliminary cost estimates were developed for both a diagnostic phase of inquiry and a preliminary series of workshops.

SECTION II - DESIGN OF ENTRY

Guidelines

1. Subgroups of (2, 3, 4) - Discuss. Based on the information contained in pp 1-6 address the following: — 20 min.

   a. What is the nature of the social system requesting help?

   b. What choices confront the change agent in responding to the request for help?

   c. Assume that you have agreed to be a consultant/change agent to this system. Identify several action strategies that could be used.

   d. Identify the one action strategy which you would actually utilize. Develop the rationale for the action strategy you plan to take and the reasons for it.

2. Subgroups report their discussions and decisions from 1 above to other subgroups. Compare and contrast subgroup positions. — 20 min.

3. Now read pages 6A through 12 of the case study. — 10 min.

Commentary on Entry: The authors, like most citizens of Cincinnati, had been somewhat aware of the troubles in the Health Department but had no first-hand knowledge of the severity or complexity of the situation. It became immediately clear, however, in our discussion with the staff psychiatrist who contacted us initially as well as in our subsequent meetings with the Commissioner and the President of the Board, that the problems of the Department had reached crisis proportions. The authors soon learned that the Board had given the Commissioner a grudging vote of confidence following receipt of an extensive list of grievances by an Ad Hoc Health Department Workers Council.

It was clear that the affairs of the Health Department had become a matter of city-wide concern and it quickly became apparent that one of the critical issues was the

deep sense of distrust around the Commissioner and his leadership role in the Department. He had become the focus of real polarization, with both sides of the polarization represented in all camps: The Department, the Board, and the community.

As the authors began to acquaint themselves with the situation in the Department through reading reports, newspaper stories, and making discreet, informal inquiries, they began to have doubts about the appropriateness of conducting communications workshops. A critical element involved in this concern was the manner in which the negotiations for the authors' services had been conducted. There had been little public discussion, either in the Board or the Department, about the need for this kind of intervention and the authors became concerned about their own credibility in this climate of distrust and polarization.

Under conditions of extreme polarization, it must be questioned if these extreme differences can be resolved in a workshop format. When circumstances have become polarized with a high degree of distrust and scapegoating, listening becomes impossible and

bringing the opposed groups together is more likely to lead to bloodshed than increased understanding. Clearly, this is a diagnostic decision that must be made by the consultant in each case; namely, is a workshop in which the opposing sides directly confront each other more likely to lead to further polarization or some resolution of the differences? Moreover, many of the grievances by the Ad Hoc Workers Council required action steps by the Commissioner. A workshop would not have been regarded as an appropriate response to those demands, a fact which further reduced the presumed utility of workshops. While there was a clear need for additional data to support the decision against conducting a workshop, this tentative decision was quickly reached by the authors, even before the contract had been agreed upon.

The authors became increasingly aware that timeliness and speed of action was absolutely critical if this crisis were to be managed in any productive fashion. At the same time, it was not at all clear to the authors what would be an appropriate set of actions to recommend for solving the crisis. The demand for prompt action and a lack of clarity about what would be appropriate

action seems to be one of the characteristics of crisis, one that has obvious and considerable consequences for crisis consultation.

As the authors became increasingly aware of the situation confronting the Health Department, they became increasingly convinced that any kind of intervention without extensive diagnosis would be inappropriate. They were well aware, however, that extensive data collecting in an organization is not without consequences. Nevertheless, between the time of the initial meeting with the Commissioner and the President of the Board and the next meeting with the entire Board, the authors adopted the stance that the only appropriate initial contact with the Department would be one for a diagnosis and evaluation of the current situation without any necessary action steps.

It should be clear in this context that a contract for a series of workshops, with or without a preliminary diagnostic phase, could have been written and that such a series of workshops could have been attempted. Indeed in a crisis climate the parties involved are often willing to attempt almost anything to reduce the conflict and restore normalcy. Presumably some consultants might have actually attempted these workshops. Based upon their prior organiza-

tional experience, however, the authors were not willing to go along with the client need in this case and accept their self-diagnosis for a workshop intervention. The need for competence in organizational analysis and a high level of professional integrity are underscored in this case. In retrospect, the unwillingness of the authors to conduct any workshops without a period of organizational assessment was clearly an extremely wise decision.

The authors next met with the Board and the Commissioner in a special meeting of the Board in order to explore what might be usefully attempted. The Board had some difficulty in understanding exactly what the authors meant by an "organizational diagnosis." It was pointed out to the Board that there probably was no one who knew all of the issues involved and that there was little objectivity in the various reports which had been reviewed by the Board. The authors suggested that they might be usefully utilized as a diagnostic team to identify the problems facing the Department and further to serve as consultants to the Board in resolving these problems. While the Board had initially been prepared to hear a proposal for a series of workshops, they were rather easily dissuaded from this expectation after some in-depth discussion with the consultants.

There was at least one member of the Board, however, who had already reached a decision as to the only appropriate course of action ----fire the Commissioner. The other members of the Board were more supportive of the Commissioner, especially when he was under attack by the one member. Indeed, it was clear to the consultants that the Board itself was polarized around the issue of the Commissioner and his role. Further, the Board was not processing or facing up to its internal disagreements and was being rendered ineffective in its functioning as a consequence. The poor quality of the Board's functioning, their inability to deal with issues openly and directly, was thus rather quickly identified by the consultants as one of the issues facing the organization.

While it was clear that the majority of the Board was supporting the Commissioner, at least for the time being, it was also rather clear that there was an uneasy tension between the Commissioner and the Board. The Commissioner's behavior toward the Board was quite proper and deferential but he was not very open or informative about the real issues confronting the organization. The Board seemed perplexed and exasperated in their attitudes toward the Commissioner. They knew that there were serious problems in the organization, were convinced that the Commissioner had a role in these problems, and were unclear about the nature of his complicity in the problems.

The Board then asked the Commissioner and the authors to withdraw and met in a brief executive session. They agreed to retain the services

of the authors as consultants for an organizational diagnosis for a period of 60 days. It was agreed that the consultants would "conduct individual interviews and group conferences with members of the Department and certain others related to the Department and its functions." Based upon the data collected in these interviews and conferences, the consultants would develop such action plans "as they considered in their professional judgment essential to the resolution of the current organizational problems." The consultants agreed that a written report of their findings and recommendations would be available to the Board by no later than December 1, 1970.

SECTION III - DIAGNOSIS/DATA COLLECTION

Guidelines

1. Subgroups. Compare your action strategy (re Entry) from section II with what the change agents actually did. — 10 min.

2. Subgroups - Discuss. While we recognize that you may have developed a different entry strategy than that actually used by the change agents in this case, in order to proceed with the case study review what was actually done (pp 1-12) and base your answers to the following on this information. — 20 min.

   a. Identify several alternative strategies for diagnosis and data collection.

      What problems do you anticipate for each of these?

   b. Consider yourself in the role of the change agent to this system. Develop an action plan for diagnosis/data collection which you would implement. What is the rationale for your plan?

3. Subgroups report their discussions and decisions from 2 above to other subgroups. Compare and contrast subgroup postions. — 20 min.

4. Read pp 12A-24 of the case study. — 10 min.

DIAGNOSIS

Several days after the drawing of the contract, a fact which was reported in some detail in the local press, a meeting was held of the major department heads and other significant persons in the Department of Health. The purpose of the meeting was to introduce the consultants to the Department and to request the cooperation of the Department in the diagnostic activities of the consultants. The President of the Board of Health introduced the consultants in an atmosphere of high tension, anger, and distrust.

A number of issues surfaced in the first few minutes of the meeting. Many of those present indicated that they wanted action on their previously articulated demands, not further inquiry into their merits. Others questioned the objectivity of the consultants since they would be

"hired hands" of the Commissioner and the Board. Still others raised questions about the professional competence of the consultants to deal in a crisis situation in a health-care agency. The consultants tried to respond to the questions concerning their competence and objectivity, attempting to defuse the situation. It was clear, however, from the constant stream of questions that this defusing was not accomplished and there was no resolution of the trust issue. The meeting broke up with the consultants feeling that they had failed to establish much credibility with those present at the meeting and that the trust issue would be an important one with which to deal.

Recognizing that there was a good deal of mistrust of them in the Department, the consultants attempted to devise a strategy which would simultaneously give them access to those persons who had been identified as principal characters in the current crisis and, at the same time, provide an opportunity for all other interested persons to discuss in confidence their grievances and other issues with the consultants. It seemed imperative that the consultants attempt to deal with all interested parties without regard to their rank or status in the Department or their prior role in the controversy. A letter was prepared for distribution over the Commissioner's signature which spelled out a role description for the consultants and specified those mechanisms by which interested persons could arrange for a meeting or interview with the consultants. Essentially, the consultants' role was described as an

"attempt to better identify and diagnose the issues and problems which have become divisive and destructive in our work" and their goal was described as promoting open and honest communication within the Department.

In response to the Commissioner's letter the following unsigned document was circulated among the workers at the Health Department: "The Workers Council recommends that the staff not meet, talk, nor give any information to the two new staff psychologists. We recommend that the Commissioner and the Board of Health meet with these therapists, since the problems in the Health Department are their problems, not ours." It is against this state of affairs that the two consultants attempted to begin their diagnostic intervention into the Cincinnati Department of Health.

The consultants attempted to clear their calendar to spend the bulk of their time on this crisis. Within several days a meeting was held with most of the department heads and assistant department heads of the Department of Health, approximately 20 in number. All of the persons present were asked to introduce themselves and describe their functional role in the Department. The consultants asked a number of questions about how their various roles interfaced and how various tasks were assigned. Questions were raised about the nature of their concerns and discontents, but the quality of the responses was guarded and non-informative. The major purpose of the meeting, however, was to familiarize the consultants

with the administrative organization of the Department and some of the cast of characters as well as to expose the consultants to this key group.

The very next day, the steering committee of the Ad Hoc Workers Council, about 20 in number, appeared for a meeting which the Commissioner had arranged. About one-half of the members of the steering committee had been present the previous day as they were either department heads or assistant heads. After a round of introductions a senior physician arose and read a prepared statement indicating that the group had met previously and had come to a unanimous decision not to engage in any dialogue with the consultants. He indicated that they had engaged an attorney, who was not present at the meeting, and all further communications would be through him. They did indicate that they felt that the only solution to the current problems would be for the present Commissioner to resign and that they feared that any statements made to the consultants would be used against them in a vindictive and punishing way, either in the form of verbal assaults or legal attempts to remove them from their positions. They generally doubted the objectivity of the consultants and questioned whether or not they could do anything helpful in the situation anyway. The next two hours were extremely long. The consultants attempted to deal directly with each of these points and to engage the group in serious dialogue. The consultants indicated that they were open to considering that one solution to the current crisis would be for the Commissioner to resign. They were not prepared to make a recom-

mendation on this matter at this time, but that was certainly one of the options that might come out of their diagnosis and study. Moreover, the consultants worked at clarifying that they wanted to get at issues and did not have any reasons for reporting the specific comments of individuals.

During the course of the two hours, despite their previous decision not to talk, many persons were won over by the open and frank manner of the consultants and their non-defensive willingness to accept the concerns and doubts about the usefulness of the consultation intervention. Moreover, the consultants indicated directly that they themselves had doubts regarding the extent to which they could have an impact which would be helpful in the current situation.

This meeting with the Ad Hoc Workers Council was a critical turning point in the consultation. The consultants felt they needed both to "buy time" and create credibility for their role, even though they themselves were uncertain about their potential influence in the crisis. Much to their own surprise, these goals were accomplished in this meeting, although there was no particular point in the meeting at which this seemed to occur nor was there an explicit decision made to assist the consultants. Rather, individuals began to provide helpful inputs and no additional memos appeared urging employees not to talk to the consultants. Following the initial difficult meeting, several members of the Workers Council voluntarily began to supply the consultants with a wide range of documents and inputs regarding the Department and their concerns. In general those

who provided information came from higher in the department hierarchy and included about equal numbers of newer and older employees. The consultants never met or talked with the attorney engaged by the Ad Hoc Workers Council. Moreover, the consultants had no ensuing contact with the senior physician who had represented the group at the first meeting with consultants.

A number of other diagnostic interviews were then conducted; over 100 persons were interviewed in all, either individually or in groups. Among the persons interviewed were the various assistant commissioners and department heads, line workers in the Department, the Board members themselves, the Director of the Pilot Cities Program, a University group which had been consulting on the computer uses in the Health Department, and others. In addition, a wide range of documents about the work of the Department, letters from the Commissioner, letters to the Commissioner, documents distributed by the Ad Hoc Workers Council, newspaper clippings and various other materials were reviewed and considered. These interviews and documents formed the data base upon which the consultants founded their conclusions and recommendations.

Commentary on Diagnosis: As Argyris (1970) notes, the first primary task of an interventionist is the development of "valid and useful information." This, however, is very difficult in a crisis climate where suspicion around loyalties and intentions is high, polarization is extreme,

and coalitions are forming with the intention of co-opting anyone they can to support their cause. Among the central coalitions in this situation were the Commissioner and his supporters, the Ad Hoc Workers Council, the Board of Health, and others. Another group which further complicated the situation was the local press which had identified a newsworthy story and wanted to pursue it to its logical conclusion.

This crisis climate seriously interfered with any information gathering on the part of the consultants. Persons were reluctant to share data because of fear of retaliation. There were groups who wanted the consultants to meet with only those individuals who would supply the information which supported their position. The press wanted complete and open sharing at a time which the consultants felt was premature and inappropriate. Therefore, the consultants felt that the first task was not the collection of data, but the establishing of credibility with as many constituent groups as possible. Only through the development of some credibility and trust does the development of meaningful information become possible. While this is always true in a consultation process, it becomes of paramount importance in crisis consultation. The meetings

with first the department heads of the Health Department and then the Ad Hoc Workers Council were critical points in the consultation process. The dialogue between the consultants and these two groups seemed to provide some basis for a temporary truce and for raising the trust level to one in which some collaboration on information-sharing, if not action, was possible. The factors which seemed to be most central in achieving this climate were: the consultants were not defensive about the role of the Board or of the Health Commissioner; they were willing to entertain the possibility that one of the findings of the investigation would be that the Commissioner should resign his position; and finally, they agreed that the community might very well have a larger and more significant voice in the conduct and affairs of the Department. Within broad perspective, these were the salient issues in the crisis.

What is important to note was the consultants' agreement that these issues ought to be openly and thoroughly discussed in the system. Such discussion had not been previously legitimized. The consultants' values are to support open communication and dialogue among those persons who are vitally concerned with the

issues being addressed. Their open commitment to these values was undoubtedly a factor in trust-building.

One technique which seemed to be of special usefulness in trust-building under these crisis conditions was listening and paraphrasing. This is both especially difficult to do and critically important in crisis consultation. There is a strong tendency in crises to advocate one's own position rather than to listen and there is little expectation of being listened to. For example, there were a number of times during the meeting with the Workers Council when they identified specific minor administrative problems that had developed, such as reimbursement for mileage on personal automobiles, problems which they felt the consultants simply would disbelieve or not even hear. When the consultants were able to paraphrase their understanding of the issue and the intensity of the workers' concerns, credibility and rapport was established.

The observation of the usefulness of this paraphrasing process made an important contribution to the diagnosis of the organization. It became clear out of this that many employees of the organization experienced their inputs about problems as not being heard, or as

responded to as "this is not a problem".

During the diagnostic phase several aspects of how the consulting team operated emerged as important considerations. The personality dynamics of the two consultants and the degree and manner in which they were open about their perceptions about the issues influenced which portions of the client system trusted which consultants around which issues. For example, the consultant who had made the initial contact with the Commissioner seemed to develop a somewhat closer working relationship with the Commissioner and was less open in the meetings with the Ad Hoc Workers Council. On the other hand, the second consultant was more open regarding the problems involving the Commissioner and his role in the meetings with the Ad Hoc Workers Council and this led to his greater credibility with that group. Based on the perceived credibility and support that constituent groups saw in the consultants, they made attempts to influence the individual consultants in directions that were more supportive of their own positions. For example, the second consultant received all of the phone calls from representatives of the Ad Hoc Workers groups and the first consultant received

almost all of the phone calls from the Commissioner.

What is important to note in this context is that the consultants were aware of their differentiated roles and regularly discussed how their differential styles led to differential credibilities, consequently, how different data was available to each of them. While there were some differences in the age and nature of consultation experiences between the consultants, these factors did not seem as critical or important as differences in personal/professional style in producing a role differentiation between the consultants. One consultant was ordinarily concerned with personal, intrapersonal, and interpersonal issues in the crisis while the other consultant focused on organizational and intergroup issues. There did not appear to be any perceived status differences between the consultants in this intervention. They used different diagnostic frameworks for assessing and integrating the data and this led to the exploration of differing sets of issues and actions. This is possible only where the consultation team views these differences as strengths facilitating the consultation process rather than sources of friction and competition. This conception of the team relationships was some-

times easier to accomplish in theory than practice. The consultants were always aware of their own anxiety regarding the risks in this consultation process, particularly in this climate of crisis.

FEEDBACK, CONSULTATION, AND NEGOTIATIONS

The intensive diagnostic phase, the series of interviews, conferences and meetings, and the readings of the documentation, lasted a little over two weeks. The manifest grievances of both the employees and the community included general complaints about the failure of the Commissioner and the Board to exercise leadership, the poor communications within the Department, the inefficiency of the Department, and specific complaints about the failure to develop adequate programs in areas like VD control, school health, neighborhood health clinics, and so on. The consultants' analysis of these manifest grievances led them to the conclusion that these were in fact problems and that the responsibility for these problems was wide-spread.

Among the underlying causes of these problems were a generalized resistance to change and innovation and an antipathy to any who attempted change or innovation. Further, the Department was organized as a traditional bureaucracy that was inadequate to meet the complex urban health needs of the city. There was ineffective overcentralization and there were inadequate professional-managerial resources for the present tasks and few for long-range planning. A part-time volunteer

Board of Health of only five members was simply inadequate to manage this complex modern Department. Also, there were a series of unresolved personality conflicts, many of which involved the Commissioner, which were interfering with the effectiveness of the Department.

Through the course of the consultation it became increasingly apparent to the consultants that the Commissioner, because of his management style, had lost his creditability, both in the Department and in the community. This point was made in interviews even by supporters of the Commissioner and it became clear that, regardless of any recommendations which the consultants might make, and the talents the Commissioner had for improving health care, the Commissioner's tenure in office was drawing to a close. Further, the press and other news media had helped create a climate of opinion in the community in which the Commissioner was seen as primarily responsible for the current situation.

SECTION IV - DATA ANALYSIS/ACTION STEPS

Guidelines

1. Subgroups. Compare your action strategy for Diagnosis/Data Collection from section III with what the change agents actually did. — 10 min.

2. Subgroups - Discuss. While we recognize that you may have developed a different diagnosis/data collection strategy than that actually used by the change agents in this case, review what was actually done (pp 1-24) and base your answers to the following on this information. — 20 min.

   a. What conclusions can be drawn from the data? Develop several possibilities.

   b. What action alternatives can be drawn from the data? Develop several possibilities.

   c. Consider yourself in the role of the change agent to this system. Develop an action plan which you would implement. What is the rationale for your plan?

3. Subgroups report their discussions and decisions from 2 above to other subgroups. Compare and contrast subgroup positions. — 10 min.

4. Read pp 24A-35 of this case study. — 10 min.

During the two-week data collection phase, as this conclusion became ever more clear, the consultants met on several different occasions with the Commissioner in order to share this conclusion with him. After several meetings the Commissioner was convinced that his resignation would be necessary and the question arose of the timing of this critical act. The consultants were concerned that his resignation might so defuse the situation that the other issues which were very much part of the current problems would go unexamined in the delight

and exultation following the Commissioner's resignation. The consultants worked closely with the Commissioner, the President of the Board, and members of the Board, with whom a number of feedback sessions were held during the week, in the timing of the announcement of the resignation in order not to dissipate the impact of their report.

In addition to the above the consultants counseled with the Commissioner and the Board in the preparation of a detailed response to the list of manifest grievances by the Ad Hoc Workers Council, a response which had not been previously made. The Commissioner was advised to establish a communications council within the department which would provide a vehicle for information exchange and dialogue about departmental problems.

While the consulting team was busy with its data gathering and data analysis, the Ad Hoc Workers Council was not quiet. They had requested time from the City Council to present their complaints about the Health Department and such time had been granted. After their initial presentation, the Council referred the matter of the Health Department to one of its standing committees, Human Resources, consisting of the Mayor and two other Councilmen.

The consulting team had decided that the simple issuing of a final report probably would not have the desired effect of initiating real changes in the Health Department and, further, the consultants had decided that their responsibility in this matter was to the broader

community of the City which was represented officially by the Council. Therefore, the consultants decided to present their findings to the Council, informally through the Human Resources Committee. The President of the Board of Health was asked to, and agreed to, arrange an informal meeting between the consultants and the Mayor. The consultants' tentative findings were shared with the Mayor and, while he was concerned about the extent and severity of the problem, he was positively impressed with the way in which the report was presented. He recognized that there was a strong data base for the findings and that the recommendations were a natural consequence of the findings. The Mayor was eager to move ahead into the action steps necessitated by the recommendations, but first wanted the consultants to share the same feedback with the two other members of the Council's Human Resources Committee.

Within the next two days a similar, informal meeting was held with the consultants and the three members of the Council committee. The findings and the recommendation of the consultants were reviewed. The committee was a bipartisan one and there were obviously potent political issues involved in this controversy. While there was some attempt to test these issues with the consultants, the three Councilmen quickly became impressed with how the findings were data based and revealed a complex and difficult situation from which neither side could really profit. The Councilmen were grateful for this early sharing of the

feedback by the consultants and indicated their willingness to support the recommendations.

Within one week after this meeting with the Councilmen, the final report of the consultants was submitted to the Board of Health. The day on which the report was received was the day on which the Commissioner's resignation was accepted. Within another week's time the entire Board of Health had resigned (at the request of the Mayor with the support of the rest of the City Council) and a decision had been made to seek a City Charter amendment which would change the nature and size of the Board of Health.

In the year following the final report, a new Board and Commissioner have been appointed, the Commissioner has begun a reorganization of the Department including an expansion of the professional managerial staff and efforts to involve the community in the affairs of the Health Department have greatly expanded. The Charter amendment expanding the Board of Health from five to nine members, shortening the term of office from ten to three years, and limiting the number of health professionals on the Board to less than five, was on the ballot in the November 1971 general election. With strong newspaper endorsement and no general opposition, this amendment was passed. Additional members to the expanded nine member Board were appointed shortly after the approval of the Charter amendment.

Commentary on Feedback, consultation and negotiations: In consultation it is usual to differentiate between short-term, medium term, and long-term consequences of the consultation process. In crisis consultation, however, the intensity of the feelings involved and the strong polarization between the groups ordinarily demands such a strong focus on short-term issues and short-term solutions that longer-term issues and solutions are ignored. It should be clear from the above analysis that the root causes of the Health Department crisis were long-term and only long-term solutions would resolve the underlying problems.

A popular short-term solution in this case would have been to simply recommend the firing of the Commissioner. There was a certain attractiveness to this as it would premit the consultants to exit themselves from a very difficult situation, would help defuse the tremendous amounts of anger and frustration present in the organization, and was an action which was readily accomplished within the limitations of their contract. As attractive as this alternative appeared, however, it was clear to the consultants that the problems confronting the Department were more complex and, to quote the consultants' final report, "these problems unless adequately resolved, will continue to plague

the Department in the delivery of health services, regardless of who serves as Commissioner." The consultants' conclusion was that, while the Commissioner and his management style were important in the current crisis, and he had indeed outlived his usefulness in his present position, there were other, equally important issues that needed to be addressed if the difficulties were to be resolved on a long-term basis. Under crisis conditions, it is difficult to help the client system attend to these longer-term considerations especially when there is a convenient short-term solution available. It should be apparent, however, that long-term solutions can only be contemplated after short-term solutions have been developed and there is a reasonably high degree of confidence that these short-term solutions will work effectively.

Another important short-term issue that has to be examined in a crisis is the day-to-day workings of the organization, someone has to "mind the store". The consultants feel there always should be some public response to the manifest problems in a crisis and some attempt must be made to open the channels of communication among the dissident groups. This was done in the present case by recommending public Board response to the grievances and

the creation of the communication council. These short-term interventions were helpful in trust building and in maintaining the level of tension within the department at a tolerable level.

As the consultants began to draw their conclusions, one issue which continually arose was that of who was the client to whom the consulting team was finally responsible. Ordinarily in process consultation (Schein, 1969) the question of who is the client is readily apparent to both the consultant and the client system. For example, in an industrial organization the client might be the President or the Board of Directors or the Director of the Research and Development Laboratory. In any of these cases the consultants would ordinarily submit their recommendations to the client with whom they had entered into a contract and accept whatever decision or action the client might choose to make with respect to their recommendations. In the present case, however, this was not the case and the issue was not simply resolved.

As noted above, the consultants had serious questions about the effectiveness of the Board, about the management style of the Commissioner, and about the openness of the Department as a whole. The consultants' final

report was equally critical of all those parties. To whom, then, should the consultants address their report? This question became critically important when the consultants realized that they would not be comfortable in having their report gather dust in a file cabinet and have the Health Department remain as ineffective as they had found it. While a consultant in an industrial organization might be willing to observe that organization die through bankruptcy, it is less easy to permit that to happen in a public service agency, particularly one committed to the delivery of health care of one's own community.

On the basis of these considerations, the consultants decided that their primary responsibility was to the larger community --- the City of Cincinnati --- rather than to the Health Department per se. This decision was not one easily arrived at and many hours of discussion went into making it. It was recognized that the initial contacts had been with the Commissioner and, in some ways, we were responsible to him; without his support we would never have been involved at all. It was also recognized that we were employees of the Board and responsible to them. Further, we had made implicit and explicit promises to the employees of the Department in our contacts

with them, promises to help them deal effectively with their problems. The issue to some extent was how these conflicting and discordant interests could be served simultaneously. One way of resolving this issue, at least for the consultants, was to view their prime responsibility as to the public whom the Department was established to serve. The City Council was the official agency representing the public and it was to them the consultants decided to turn.

Sharing findings with representatives of Council was outside the formal contract which defined the Board and Commissioner as the client. The Board president unilaterally agreed to extend the contract to include dialogue with Council inasmuch as he was interested in doing whatever was possible to solve what was for him a personally difficult situation. Further, he agreed that both the political dimensions of the crisis and any long-term solution would require political as well as organizational changes. Prior to seeking a meeting with City Council the consultants had informally shared the findings and their recommendations with members of the Board and the Commissioner. Although apprehensive about changing the contract in this fashion the consul-

tants saw and still see the action as necessary and appropriate. Consultants working in public agencies may find the nature of their role, contract, and client system to be evolutionary and fluid rather than stable and fixed.

The experience of the consultants in this case suggests the utility of this kind of crisis intervention in the political arena where the interventionists are seen as objective and unbiased and are willing to operate from a data base. This general approach has been used previously in royal commissions, "blue ribbon" panels, and the like, but this has generally been a rather unusual role for behavioral scientists to perform, especially in a crisis.

The recommendations of the consultants, all of which have either been carried out or are being carried out, involved the resignation of the Commissioner, the reorganization of the Department, the expansion of the professional-managerial staff of the Department, and the reconstitution of the Board of Health. Acceptance of these recommendations required a careful set of negotiations, the completion of which was necessary prior to the public release of the consultants' report. These negotiations included informal information sharing with significant power figures, preventing the recommendations from becoming partisan political

issues, preparing expectations about the scope and nature of their findings and recommendations, providing "face saving" opportunities for those who were perceived as "guilty", and generating commitment to implementing the recommendations; all of which were necessary in the opinion of the consultants to attain the long-term changes necessary to resolve the crisis. Whether or not behavioral science consultants can be similarly effective in other political systems can not be determined. But, it is clear that such a negotiation process is essential to the management of crises in the political arena.

One side effect of the negotiation process employed was to maintain a cordial relationship between the consultants and all of the other protaganists. At the conclusion of the consultation there seemed to be a wide-spread feeling on the part of all the principles, including the Mayor, Board, City Council, Commissioner and the Ad Hoc Workers Council that the consultants had fulfilled the role of unbiased, "honest brokers". Perhaps it was this shared perception of the consultants that permitted the high degree of acceptance of their findings and recommendations. On the other hand, however, the consultants were never again used by the Department following the submission of the final

report. This suggests that when crisis consultation leads to the drawing of "organizational blood", the consulting team has used up its creditability with the organization.

In retrospect it is also clear to the consultants that participation in this kind of project turns out to be heady stuff, indeed. Within a period of less than two months, the consulting team had managed to secure the resignation of the Commissioner of Health, the resignation of the entire Board of Health (the first time this had ever occurred in over 100 years), had the City Council pass a resolution to pursue a charter change to increase the size of the Board, and generally changed the psychological climate of a major city agency. How the consultants managed to maintain noble disinterest in their own potency during this period of great political influence is for the reader to decide.

We have noted that there was a considerable amount of newspaper and other press coverage of the crisis in the Health Department. We would be overly modest if we did not note that the evening newspaper, shortly after the final events described above, editorialized as follows: "A word of thanks is in order to psychologists Dr. Ronald K. Boyer and Dr. Leonard D. Goodstein .... of the University of Cincinnati, for their penetrating and civic-minded studies of the inadequacies of the Health Department." The editorial concluded, "Now comes the hard work of drawing up sound plans and getting on with reconstruction."

References

Argyris, C. Intervention theory and method: A behavioral science view. Reading, Mass.: Addison-Wesley, 1970.

Schein, E. H. Process consultation: its role in organization development. Reading, Mass.: Addison-Wesley, 1969.

Footnotes

[1]The authors acknowledge their indebtedness to Robert J. Aiduk and Joseph Melnick for their considerable assistance in the conduct of this consultation and to William N. Dember and Richard E. Walton for their assistance in the preparation of this manuscript.

[2]The reader may question the ethics or at least the propriety of preparing this document. The authors were very much aware of these issues and made the decision to go ahead with a public sharing only after considerable debate and discussion. It should be noted that all of the issues covered in this presentation, including those involving individuals, were a matter for open discussion in the local press for several months. We have taken considerable care not to present any data which was not previously presented in our final report to the Board, which was a public document. Nevertheless, we are well aware that this still wider circulation of these issues may cause some discomfort to the persons involved. We do feel, however, that the potential learning about crisis intervention implicit in this report justifies its publication.

SECTION V - REVIEW

Guidelines

1. Subgroups. Compare your action strategy for Data Analysis/Action Steps with what the change agents actually did. — 10 min.

2. Subgroups meet together to discuss their learnings from the case and discuss such questions as: — 30 min.

   a. What have I learned about myself as a participant and actor in organizations?

   b. What have I learned about my organizational beliefs, values, feelings, and what have I learned about how these affect what I do or do not do in organizations?

   c. What is my/our conception of the change agent's (consultant's) role?

   d. What theories of organization and change do I/we employ in looking at organizations?

   e. Other????

— THIS IS THE END —